Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

☒ Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
☒ Title of Alternative Benefit Plan I: Birth to 3 Benchmark Plan
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

☒ **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

(i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low- income children eligible under		

		1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • •		

☒ (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Mandatory categorically needy low-income parents eligible under 1931 of the Act	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
X	Individuals qualifying for Medicaid on the basis of blindness	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
X	Individuals qualifying for Medicaid on the basis of disability	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		

X	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
X	Disabled children eligible under the TEFRA option - section 1902(e)(3)	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
X	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

- Infants and toddlers who meet all the financial and non-financial eligibility criteria for Medicaid and also meet the eligibility criteria for the IDEA, Part C, Wisconsin's Birth to 3 Program, including is:
  - between birth and 36 months of age
  - meets level of care eligibility as determined by the county early intervention team
  - meets Wisconsin residency requirements and lives in a non-residential/institutional living situation
  - experiencing developmental delay(s) as evidenced by a minimum of a 25% delay in any one area, or
  - diagnosed with a condition known to result in a development delay

Opt-In Enrollment	**Included Eligibility Group and Federal Citation**	**Targeting Criteria**	**Geographic Area**
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

☒ (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolle in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

The time period during which parents and guardians are determining a suspected diagnosis and/or determination of disability or developmental delay of their child is a stressful time. To minimize additional stress on the family system and ensure that the aligning of early intervention services, assessment and care needs are addressed, this program will enroll children into the Birth to 3 alternative benchmark program on a voluntary basis, as determined by the parent or guardian.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform county birth to 3 agencies, families, advocates, and the community about the program:

1. The state, through its Department of Health Services will hold information sharing meetings with the Governor appointed Interagency Children's Council (ICC), county birth to 3 agencies, parents, local school districts, service providers and partners, as well as community and advocacy groups across the state.

   These sessions will serve as a forum for the state to explain the new benefit, respond to questions, and to solicit feedback on its outreach strategies. In addition to explaining the framework for the enhanced services, the state will emphasize two points in its communications:

   a. There is no reduction in the benefit package offered to this population; they will continue to receive the full benefit package.
   b. There is no cost sharing for this service.

   The state will hold separate meetings with Tribal representatives to obtain their recommendations. Children who are identified as American Indian or Alaskan Native will be exempted if it is the recommendation from the Tribes.

2. The state will develop informing materials that:

   a. Identify the Birth to 3 participants who may be voluntarily enrolled in the program.
   c. Clearly inform families that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the benchmark services, including the potential for increased access to services, as providers will receive an enhanced rate under the benchmark plan.
   e. Provide a toll-free contact number for questions and information.

3. Each infant or toddler receives a screening and multi-disciplinary evaluation (MDE) prior to determining Birth to 3 eligibility and enrollment in the benchmark plan, which determines the need for early intervention services. Based on the results of the MDE an individual family service plan (IFSP) is developed and early intervention services that meet the child's needs are identified. Additionally, family assessments are completed to determine the resources, priorities and concerns of the family and to identify necessary services and supports. Medicaid/early intervention and/or State/County funds may be utilized for the provision of early intervention and other services in excess of the state's institutional cost limit. County birth to 3 agencies inform families of infants and toddlers of these alternate funding sources at the time the change in the child's condition is identified.

   Any infant or toddler affected by the State's institutional cost limit will be offered the opportunity to request a Fair Hearing regarding their Birth to 3 benchmark plan service decisions.

   County Birth to 3 agencies are responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to families.
   b. Informing families about the voluntary nature of the program, including how to discontinue their participation.

c. Informing families that there is no cost or reduction of benefits; emphasizing this benefit is offered to complement the services already covered under Medicaid.
d. Educating families about the benefits of participating in this program, for example, improved coordination between health care providers.
e. Documenting all requests for disenrollment.

4. The state will issue direct mailings to families informing them about their enrollment in the program, the period of enrollment, and the benefits of the program.
5. Families of infants and toddlers eligible for the Birth to 3 benchmark plan are informed of feasible alternatives available by service coordinators, along with other feasible funding and program alternatives in the home and community. Service coordinators offer the family the choice of receiving benchmark plan funded IFSP services.

6. Before the family is offered the choice of services, the service coordinator is responsible to assure that the family is informed: 1) of other feasible funding alternatives for the child, such as Early Periodic Screening, Diagnosis and Treatment (EPSDT), and county-funded early intervention; 2) that services authorized in the child's IFSP will not be affected by the family's choice to receive or not receive benchmark plan funded services; 3) that benchmark plan funded IFSP services can be authorized in conjunction with other services the child needs as part of the IFSP; 4) of other funding streams, such as federal, state and county early intervention revenues and the Medicaid/Early Intervention Fee Schedule; 5) that benchmark plan funded IFSP services must occur in natural environments with the participation of the family or caregiver; and 6) that the family can change their choice to receive or not receive benchmark plan funded IFSP services at any time.

7. The family's choice to receive Birth to 3 benchmark plan services will be documented on the IFSP. The notice regarding fair hearing rights for the Birth to 3 benchmark plan will also be provided to families.

8. The state will send written notification to the family and inform the health care coordinator of all disenrollments. The notification to the family will explain that the child's regular benefit package will remain unchanged. The State of Wisconsin ensures equitable access and participation in programs and services for eligible infants and toddlers through the availability of all public awareness brochures, posters and information materials in English and Spanish languages. Early Intervention Services regulations, DHS 90 require that tests and other evaluation materials and procedures, including translation and interpretation, are administered in the parent's native language unless it is clearly not feasible to do so. In addition, assessment and evaluation procedures are administered so as not be racially or culturally discriminatory. County Birth to 3 agencies are required to take steps to ensure that notices are translated orally or by other means when the native language of the parent is not a written language. The DHS offers interpreters for public meetings or hearings as needed.

☒ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☒ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

Birth to 3 participants that voluntarily choose to enroll in the Birth to 3 benchmark plan will be covered on a Statewide basis.

☒ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

☒ The State/Territory will provide the following alternative benefit package (check the one that applies).

a) ☒ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

☐ The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

☒ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan includes the early intervention services described below, focused on the specific needs of children with suspected or diagnosed developmental disabilities or delay that are enrolled in the Birth to 3 Program. The intention is to link children with identified health needs to services and resources in a coordinated effort to ensure the effective delivery of services.

1. The benchmark plan benefits will includes the following:

   a. Screening
   b. Developmental Treatment Services
   c. Teaming/Consultation Services (under Primary Coaching)
   d. Developmental Therapies (including speech, occupational and physical therapy)
   e. Support and Service Coordination - Care Management

☐ Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan:

☒ a. The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

☐ b. The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

☒ c. The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

For a description of the scope of benefits under this Birth to 3 benchmark plan see Attachment 1

b) ☒ Benchmark-Equivalent Benefits.
Please specify below which benchmark plan or plans this benefit package is equivalent to:
(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

☒ Inpatient and outpatient hospital services;

☒ Physicians' surgical and medical services;

☒ Laboratory and x-ray services;

☒ Coverage of prescription drugs;

☒ Mental health services;

☒ Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

☒ Emergency services;

☒ Family planning services and supplies.

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or
- categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) ☐ Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

3. Service Delivery System

Check all that apply.

☒ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

☒ The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

☒ As an Additional benefit under section 1937 of the Act

☒ The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

☒ The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

☒ The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Standard Plan via a transportation broker.

☒ The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

☒ The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

☒ The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

☒ The State/Territory will implement this State/Territory Plan amendment on October 1, 2011 *(date).*

ATTACHMENT 1

Benefits Comparison for Alternative Benefit Plan B: Birth to 3 1937 SPA

Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services

- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:

    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older

- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services

Services Outside the Medical Home Contract

The all-inclusive rate for the Foster Care Medical Home would include all services covered under Medicaid/Standard Plan, except:

- Non-emergency transportation services
- Targeted case management services*
- School-based services*
- Directly observed therapy (DOT) for individuals with tuberculosis
- Crisis intervention services*
- Community support program services*
- Comprehensive community services*
- Pharmacy services

*The Medical Home provider will be required to establish a working relationship (for example, through a memorandum of understanding) with these entities to ensure that services to the member is coordinated.

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ **Title of Alternative Benefit Plan H: Community Recovery Services (CRS) Benchmark Plan**

1. Populations and geographic area covered

X a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)

The State/Territory will provide the benefit package to the following populations:

☐ (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age, or the individual has aged out of foster care, is under 26 years of age and qualifies on the basis of section 1902(a)(10)(A)(i)(IX).

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required	Voluntary	Full-Benefit Eligibility Group and	Targeting	Geogra

Enrollment	Enrollment	Federal Citation	Criteria	phic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: •		

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Voluntary Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	**Mandatory categorically needy low-income families and children eligible under 1931 of the Act**	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	**Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):**	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and over. Falls within limit on *See footnote which follows this table. by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	**Individuals qualifying for Medicaid on the basis of blindness**	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	**Individuals qualifying for Medicaid on the basis of disability**	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established	WI Counties May Opt-In to be Certified to Provide this Benefit.

		by county of residence.*	
X	**Individuals receiving SSI. 1902(a)(10)(A)(i)(I)**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(VII)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
X	**Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
X	**Disabled children eligible under the TEFRA option - section 1902(e)(3)**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
	Medically frail and individuals with special medical needs		
X	**Children receiving foster care or adoption assistance under title IV-E of the Act**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to be served established**	**WI Counties May Opt-In to be Certified to Provide this Benefit.**

***See footnote which follows this table.**

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Supersedes_____ Approval Date_____ Effective Date_____

		by county of residence.*	
X	An individual who received foster care assistance under title IV-E of the Act, and qualifies on the basis of 1902(a)(10)(A)(i)(IX)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	At or Below 150% of FPL. Functional Eligibility Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Receiving home and community-based waiver services who would only be eligible for Medicaid under the State plan if they were in a medical institution. 1902(a)(10)(A)(ii)(VI)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on	WI Counties May Opt-In to be Certified to Provide this Benefit.

*See footnote which follows this table.

		number of persons to be served established by county of residence.*	
X	Individuals under age 21 who are under State adoption agreements. 1902(a)(10)(A)(ii)(VIII)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. *See footnote which follows this table. number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Receiving only an optional State supplement which is more restrictive than the criteria for an optional State supplement under title XVI. 1902(a)(10)(A)(ii)(XI)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Working disabled individuals who buy in to Medicaid (BBA working disabled group). 1902(a)(10)(A)(ii)(XIII)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Individuals under age 21 who were in foster care on 18th birthday. 1902(a)(10)(A)(ii)(XVII)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over.	WI Counties May Opt-In to be Certified to Provide this Benefit.

		Falls within limit on number of persons to be served established by county of residence.*	
X	**Individuals eligible as medically needy under section 1902(a)(10)(C)**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

***[From section 1.a)(ii)] In accordance with federal Benchmark legislation and rules, Wisconsin offers the CRS Benchmark Plan notwithstanding and without regard to comparability within the meaning of Social Security Act § 1902(a)(10)(B) [42 USC § 1396(a)(10)(B)] Among other things, the principle of comparability of amount, duration and scope of services prohibits states from imposing enrollment caps or otherwise limiting the number of persons eligible for services. Consistent with other provisions of federal law that permit states to offer medical assistance benefits without regard to comparability of amount, duration and scope of services, the federal Benchmark legislation and rules authorize states that offer Benchmark plans to limit the number of persons served by those plans.**

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. &1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

Participation in the CRS Benchmark Plan is entirely voluntary, and all potential participants will be informed of this prior to enrollment in the benefit. The individual's care manager will inform the potential benefit recipient, and/or his/her legal representative, both verbally and in writing that they may choose at any time not to participate in the benefit. Copies of such notifications shall be kept in the individual's case file. Determination of eligibility for enrollment in the CRS Benchmark Plan is based upon:

- **An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;**
- **Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such**

as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;

- **A determination that service-specific additional needs-based criteria are met.**

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) ☐ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

☐ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to one or more of the three standard benchmark plans specified above or to the full State plan benefit.

b) ☐ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

☐ (i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

☐ Inpatient and outpatient hospital services;

□Physicians' surgical and medical services;

□Laboratory and x-ray services;

□Coverage of prescription drugs

□Mental health services

□Well-baby and well-child care services as defined by the State/Territory, including age appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

□Emergency services

□Family planning services and supplies

(ii) Additional services
Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

□ (iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Please insert a copy of the report.

☐ (iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) **X** Additional Benefits

If checked please insert a full description of the additional benefits including any limitations.

Psychosocial Rehabilitative Services:

Community Living Supportive Services (CLSS)

This service covers activities necessary to restore individuals with severe and persistent mental illness to their best possible functional level, allowing them to live with maximum independence in community integrated settings. Activities are intended to assure successful community living through utilization of skills training, cuing and/or supervision as identified by the person-centered assessment. CLSS services focus on meal planning/preparation, household cleaning, personal hygiene, self-administration of medications and monitoring symptoms and side effects, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills. The tasks on which CLSS focuses, such as meal planning, cleaning, etc. are not done for the individual, but rather the participant is assisted in becoming more independent in accomplishing these tasks through training, cueing, and supervision.

Wisconsin would make these services available in a variety of community locations that encompass residential, social/recreational, and business settings. Residential settings are limited to an individual's own apartment or house, children's foster homes, supported apartment programs, adult family homes (AFH), residential care apartment complexes (RCAC), and community based residential facilities (CBRF's) of from 5 to 16 beds (inclusive) and including those comprised of independent apartments. The type of residential setting needed would be as agreed upon in the person-centered assessment. Individuals needing services in a CBRF setting would be those whose health and safety are at risk without 24hr supervision. Payment is not made for room and board including the cost of building maintenance.

The 1937 CRS Benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving the 1937 CRS Benefit:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State.

RCACs are by definition independent apartments with a lockable entrance and exit, a kitchen including a stove and individual bathroom, sleeping and living areas. RCAC settings are apartment complexes that offer additional services and supports to its residents. These settings are the individual's home apartment. As in any apartment setting, the owner/manager of the building may have rules or limitations to manage the building and the day to day management of the environment and services. The state has administrative rules and quality oversight that assure individuals' rights and safety in such settings.

Care Managers would be responsible for determining that AFH's offer individuals opportunity to participate in community activities. AFH's would need to offer private personal quarters or the choice of whom to share their room with and access to food and food preparation areas.

CBRF's are the most restrictive of the community residential options which is a facility that provides from 5 to 16 beds (inclusive). For this reason, only individuals whose health and safety are at risk without 24hr supervision will receive 1937 services in a CBRF. The care manager together with the person receiving 1937 services will determine that the residence is a community setting and offers opportunities for independence, choice, and community integration. Wisconsin has developed standards to ensure that these facilities are community based.

<u>Supported Employment</u>

This service covers activities necessary to restore individuals with severe and persistent mental illness to their best possible functional level in connection with obtaining and maintaining competitive employment. This service may be provided by an agency or individual employment rehabilitation specialist. The service will follow the Individual Placement and Support (IPS) model recognized by SAMHSA to be an evidence-based practice. This model has been shown to be effective in helping individuals overcome the symptoms and manage the behaviors associated with severe and persistent mental illness such that they may obtain and maintain competitive employment. This in turn promotes recovery through a community integrated socially valued role and increased financial independence.

The core principles of this approach are:

- **Participation is based on consumer choice. No one is excluded because of prior work history, hospitalization history, substance use, symptoms, or other characteristics. No one is excluded who wants to participate.**

- **Supported Employment services are closely integrated with mental health treatment. Employment rehabilitation specialists are part of the mental health treatment team and meet with the team frequently to coordinate treatment plans.**
- **Restoring function to obtain and maintain competitive employment is the goal. The focus of the rehabilitative service is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.**
- **Treating and managing the symptoms and behaviors associated with the participant's mental illness to facilitate job search starts soon after a consumer expresses an interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like pre-vocational work units, transitional employment, or sheltered workshops).**
- **Follow-along services are continuous (provided there remains an assessed need). Individualized services to address symptoms and behaviors that may interfere with maintaining employment continue as long as the consumer wants assistance (provided there remains an assessed need).**
- **Consumer preferences are important. Choices and decisions about work and needed services are individualized based on the person's preferences, strengths, and experiences.**

The service covers employment-related rehabilitative service intake, assessment (not general intake and assessment), services to assist in individual job development, job placement, work related symptom management, employment-related mental health crisis support, and follow-along services by an employment rehabilitation specialist. It also covers employment rehabilitation specialist time spent with the individual's mental health treatment team and Vocational Rehabilitation (VR) counselor (to coordinate service plans). The Wisconsin 1937 Supported Employment services will not duplicate other services covered under Wisconsin's Medicaid State Plan. The Supported Employment service does not include services available as defined in S4 (a) (4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which are otherwise available to the individual through a program funded under s. 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

<u>Peer Supports</u>

Individuals trained and certified as Peer Specialists serve as advocates, provide information and peer support for consumers in community settings. All consumers receiving 1937 peer support services will reside in home and community settings. Under direct supervision by a mental health professional, Certified Peer Specialists perform a wide range of tasks to assist consumers and/or families in regaining control over their lives and over their own recovery process. Peer Specialists function as role models demonstrating techniques in recovery and in ongoing coping skills through: (a) offering effective recovery-based services; (b) assisting consumers in finding self-help groups; (c) assisting consumers in obtaining services that suit that individual's recovery needs; (d) teaching problem solving techniques; (e) teaching consumers how to identify and combat negative self-talk and how to identify and overcome fears; (f) assisting consumers in building social skills in the community that will enhance integration opportunities; (g) lending their unique insight into mental illness and what makes recovery possible; (h) attending treatment team and crisis plan development meetings to promote consumer's use of self-directed recovery tools; (i) informing consumers about

community and natural supports and how to utilize these in the recovery process; and (j)assisting consumers in developing empowerment skills through self-advocacy and stigma-busting activities. Peer Specialists includes Parents or other adult family caregivers of children with mental illness or co-occurring substance use disorders who provide peer services to other families with a youth with mental illness or co-occurring substance use disorders.

3. Service Delivery System

Check all that apply.

X The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

X The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures that prior to submitting this State plan amendment the State/Territory provided the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment and included in the notice a description of the method for complying with the provisions of §440.345 and sections 5006(e) of the American Recovery and Reinvestment Act of 2009, as required by

§440.305(d). Please provide copies of public notices, publication dates and a list of any public meetings.

Wisconsin assures that proper notice requirements will be observed immediately following the decision to officially pursue a 1937 SPA.

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

☐ As an Additional benefit under section 1937 of the Act

X Per §440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of theses processes in order to ensure individuals have access to the full EPSDT benefit.

The State assures that additional benefits will be provided for individuals under 21 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Additional benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary.

Notification will be via the same prior authorization process Wisconsin has in place to provide Medicaid coverage of EPSDT "other services" that are not otherwise covered under the State Plan. Providers are made aware through the EPSDT provider handbook and the covered services sections of other online provider handbooks.

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

X The State/Territory assures that there is no significant difference in cost sharing, lifetime or annual dollar limits, or treatment limits between mental health/substance abuse disorder benefits and medical/surgical benefits.

X The State/Territory assures that family planning services and supplies are covered for individuals of

child-bearing age.

X The State/Territory assures that if the benchmark/benchmark-equivalent plan includes cost-sharing the State/Territory will comply with the cost-sharing rules under section 1916 and 1916(A) of the Act and 42 CFR §447.50-82, and has described such cost sharing in section 4.18 of the State plan.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on **January 1, 2012**.

1937 CRS Benchmark Benefit Plan — Attachment A

Financial Eligibility

1. **Income Limits.** Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1937 provided they meet all other requirements of the 1937 State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

Functional Eligibility

1. Eligibility for the 1937 CRS Benchmark benefit is determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). Independent evaluations/reevaluations to determine whether applicants are eligible for the benefit are performed directly by the Medicaid agency.

The1937 program will use Wisconsin's Functional Eligibility Screen for Mental Health and Mental Health & AODA (Co-Occurring) Services in doing the independent evaluation of needs based criteria. This will be conducted by a trained certified screen administrator. Certified screeners are knowledgeable about mental health issues, interviewing skills needed to gather information, conducting a holistic dialogue, recovery-based best practices, including learning what the person needs help with within a larger, recovery-focused dialogue that includes the person's strengths, values, goals and perspectives. All persons administering the functional screen must meet the following conditions:

1. Meet the following **minimum criteria for education and experience**:
– Nursing license or a BA or BS, preferably in a health or human services related field, and at least one year of experience working with people with chronic needs, or
– Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise; and
2. Meet all **training requirements** as specified by the Department. Currently that means:
– Completing the online course, or
– Attending an in-person training by Department staff (or watching video of same), **and**
– Reading and following screen instructions.

Wisconsin's Mental Health and AODA functional screen has been in use since 2005 to identify individual's functional needs. The screen has three sections: Community living skills inventory, crisis and situational factors (factors such as a history of inpatient stays, emergency detentions, suicide attempts etc.) and risk factors (substance use, housing instability etc.). The functional screen is web based and can be completed only by certified screeners. The needs based eligibility criteria are incorporated into the screen logic to provide an automated determination of eligibility or ineligibility. The functional screen will be completed annually. Screen reports are available showing when annual screens are due or are late.

2. Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS. The criteria take into account the individual's support needs, and may include other risk factors:

Wisconsin's 1937 needs based criteria requires an individual to have a variety of combinations of risk factors and functional need for assistance with community living skills such that those needs cannot be met by an outpatient clinic service. ("Assistance" is defined as including any kind of support from another person (monitoring, supervising, reminders, verbal cueing, or hands-on assistance) needed because of a physical, cognitive, or mental health condition disorder) The following is the minimum possible combinations of factors that demonstrate 1937 eligibility:

The criteria for eligibility group seven (the lowest level of eligibility) are that the individual's needs can not be met by an outpatient clinic service plus they meet the following:

- Applicant meets at least one Eligibility Group Two criteria

OR

- Applicant meets at least one Eligibility Group Three criteria

-AND-

At least 3 of the following are true for the applicant

- Needs assistance to work or to find work less than monthly OR needs assistance with schooling less than monthly
- Needs help with home hazards 1 to 4 times a month
- Needs help to use effective social/interpersonal skills
- Needs help with money management 1 to 4 times a month
- Needs help with maintaining basic nutrition 1 to 4 times a month
- Needs help with transportation because person cannot drive due to physical, psychiatric

Group Two eligibility criteria normally require two of the following but any one of these criteria meets the first part of the group seven requirement.

- Needs help in maintaining basic safety
- Needs assistance to manage psychiatric symptoms more than once a week
- Needs assistance with taking medications 2 to 6 days per week OR needs monitoring medication effects 2 to 6 days per week
- Has required use of emergency rooms, crisis intervention or detox units 4 or more time in the past year OR has had 1 to 3 psychiatric inpatient stays within the past year OR has had 1 to 3 emergency detentions within the past year
- Has had 4 or more psychiatric inpatient stays within the past 13 months to 3 years OR has made 4 or more suicide attempts within the past 13 months to 3 years
- Has had incidents of physical aggression 4 or more times within the past year OR has had involvement with the corrections system 4 or more times within the past year

Group 3 eligibility requires three of the following but for Group seven only one of the following is sufficient to meet the first part of the eligibility.

- Needs assistance to work more than 1 time per week
- Needs help with home hazards more than once a week
- Needs help with money management more than once a week
- Needs help with basic nutrition more than once a week
- Needs help performing general health maintenance at least 1 to 4 times a month
- Needs help managing psychiatric symptoms 1 to 4 times a month

- Needs assistance with taking medications 1 to 4 days a month or needs monitoring medication effects 1 to 4 days a month
- Has required use of emergency rooms, crisis intervention, or detox units at least 1 time in the past year; or has had 1 to 3 psychiatric inpatient stays within the past year
- Has required use of emergency rooms, crisis intervention, or detox units 4 or more times within the past 13 months to 3 years; OR has had at least 1 psychiatric inpatient stay within the past 13 months to 3 years OR has made at least one suicide attempt within the past 13 months to 3 years.
- Has had at least 1 emergency detention within the past 13 months to 3 years
- Has had at least 1 incident of physical aggression in the past year; OR has had involvement with the correctional system 4 or more times within the past 13 months to 3 years
- Currently homeless (on the street or no permanent address) OR has been evicted 2 or more times in the past year; OR homeless more than half of the time in the past year; OR currently homeless, not in transitional housing OR in Transitional Housing – Mental Health, Substance Abuse or Corrections System
- Has demonstrated self-injurious behaviors within the past year; OR has demonstrated self-injurious behaviors 13 months to 3 years ago
- Has at least one Substance-Related diagnosis except nicotine dependence or other related disorder; OR in the past 12 months, person has experienced negative consequences in legal (including OWI), financial, family, relational, or health domains that are linked to substance use

3. **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

4. **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in the home or in the community, not in an institution. Each individual receiving services through the 1937 CRS Benchmark benefit:

   (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

   (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State.

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan B: Foster Care Medical Home
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

(i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible f Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;

- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
	x	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • Non title IV-E Foster Care	Excludes children in a secure facility or a Residential Care Center. Coverage could be continued	Southeast Wisconsin, including Kenosha, Milwaukee, Ozaukee, Racine, Washington, and

			for a period after a child leaves out-of-home care	Waukesha Counties. Based on the lessons learned in this area, a future plan for statewide expansion will be submitted.

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
x	Children receiving foster care or adoption assistance under title IV-E of the Act	Excludes children in a secure facility or	Southeast Wisconsin, including

		a Residential Care Center. Coverage could be continued for a period after a child leaves out-of-home care – see Section 2 "Description of the Benefits – Secretary-Approved Coverage."	Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha Counties. Based on the lessons learned in this area, a future plan for statewide expansion will be submitted.
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,

- The individual was given ample time to arrive at an informed choice,
- The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

The time of a child's entry into out-of-home care represents a traumatic period for children and parents alike. To minimize additional stress on the family system and ensure that the immediate medical assessment and care needs are addressed, this program will initially enroll all children into the alternative benchmark program, as the program includes the full benefit package under the Medicaid/Standard Package and adds a component that is critical for this vulnerable population -- health care coordination. Therefore, the program will operate on an all in/opt out model. An authorized medical decision maker for a child will have the option of disenrolling the child after six months.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, Tribal governments, advocates, and the community about the program:

1. The state, through its Department of Health Services and the Department of Children and Families, plans to hold information sharing meetings with birth parents, foster parents, adoptive parents, the courts, local child welfare agencies (county and Tribal), established community and advocacy groups in the six-county area.

   These sessions will serve as a forum for the state to explain the new benefit, respond to questions, and to solicit feedback on its outreach strategies. In addition to explaining the framework for the enhanced services, the state will emphasize three points in its communications:

   a. There is no reduction in the benefit package offered to this population; they will continue to receive the full benefit package.
   b. There is no cost sharing for this service.

c. Participation will be automatic upon entry into out-of-home care, with voluntary opt-out after the first six months.

The state will hold separate meetings with Tribal representatives to discuss the program as it would affect American Indian and Alaskan Native children and will obtain and follow their recommendations.

2. The state will develop informing materials that:

   a. Identify the geographic area and the population to be enrolled in the program.
   b. Explain the nature of the voluntary enrollment, including the period of enrollment, exemption criteria, and the opt-out process
   c. Clearly inform families that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the enhanced services, including having a child-specific care plan that is multi-disciplinary; addresses access and coordination across the full spectrum of the child's needs – from preventive services and health screenings, to specialty medical care, inpatient care, and crisis intervention.
   e. Provides a toll-free contact number for questions and information.

3. The state will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to families.
   b. Informing families about the voluntary nature of the program, including how to discontinue their participation.
   c. Letting families know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
   d. Educating families about the benefits of participating in this program, for example, improved communication and coordination between health care providers, child welfare and the family.
   e. Documenting all requests for disenrollment.

4. The state will make direct mailings to families informing them about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first six months.

5. The state will send written notification to the family and inform the health care coordinator and the child welfare worker of all disenrollments. The notification to the family will explain that the child's regular benefit package will remain unchanged. The state will include the number for the Enrollment Specialist, should the family have follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.
- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.
- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.
- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.
- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X☐ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

☐The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X☐ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan covers all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of children in out of home care. A key component is health care coordination, including: (a) medical care plan development that addresses physical, dental and behavioral health needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation. The intention is to link children with identified health needs to services and resources in a coordinated effort to ensure the achievement of desired health outcomes and the effectiveness of health and related healthcare services. The medical care will be child-centric, trauma informed, and evidence-based. Service provision will include open and flexible scheduling.

1. Benefits will be provided under a medical home framework that includes the following:

a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to children in foster care;
b. Coordination of health care through a multidisciplinary team, including the primary care physician, that works to identify and meet the medical needs of children in out-of-home care. The team identifies the health needs of each child, creates a care plan, and ensures that each child is assigned a care coordinator;
c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), institutional care, chronic care and other specialty care;
d. Services provided through open and flexible scheduling;
e. Comprehensive transitional care as a child moves from one setting to another; and
f. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of children in out-of-home care and on comprehensive care coordination, will assure a child-centric focus and continuity of care. The care manager will collaborate with the family to identify providers who are experienced in meeting the needs of this population. A more streamlined prior authorization process will apply with respect to OT, PT, speech and mental health services. The plan will attract providers by allowing enhanced, flexible services.

3. Providers will be required to ensure services under EPSDT based on best practices and each child's needs, including:

a. timely and trauma-informed screening, assessment and referral, including comprehensive mental health screening;
b. evidence informed and comprehensive interventions in children's mental and behavioral health;
c. mobile response and stabilization services;
d. oversight of psychotropic medication, including pharmacist consultant services;
e. enhanced schedule for physical, behavioral and dental care as necessary.

4. To ensure the continuity of care for these children, this plan will authorize participation for up to 12 months after a child exits out-of-home care. Continuation in the plan would be contingent on Medicaid eligibility and a judgment of necessity by the multidisciplinary care coordination team.

Note: For a summary of benefits under this Foster Care Medical Home Initiative and the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.
Please specify below which benchmark plan or plans this benefit package is equivalent to:
(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent

coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x☐ Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

Children in out-of-home care often have difficulty accessing appropriate medical and behavioral health care in the Medicaid fee-for-service delivery system. Medical and behavioral care is often fragmented, with no overall care coordination. In addition, many children in out-of-home care have involved medical and behavioral health needs and often lack an accessible, adequately documented medical history. This plan provides care coordination and enhanced services for children in out-of-home care in southeast Wisconsin, where over half of the children in out- of-home care are living. The plan includes all benefits, including EPSDT, under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of these children:

- A medical home framework specific to children in out-of-home care:
- Comprehensive medical assessment and treatment, including for behavioral health, based on best practices and the needs of each child;
- Comprehensive dental services;
- As deemed necessary by the care coordination team, up to 12 months of continued eligibility for coverage under the plan when a child moves to permanent placement. Contingent on continued Medicaid eligibility.

The Department will certify one or more health systems to provide a medical home for children in the target population. A health system in this context means a group of physicians and other licensed medical practitioners that also includes a hospital affiliation.

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-

service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date)*.

Attachment 1: Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services
- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older
- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Nurse midwife services

- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services

DRAFT PW UPDATED 10/21/11

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan F: Medical Home Pilot to Promote Healthy Birth Outcomes for Pregnant Women
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;

- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	Pregnant women not enrolled in an HMO	Southeastern Wisconsin
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
	X	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI recipients • 1902(a)(10)(A)(i)(I)	Pregnant women not enrolled in an HMO	Southeastern Wisconsin
	X	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	Pregnant women not enrolled in an HMO	Southeastern Wisconsin
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: •		

X (ii) The following populations will be given the option to voluntarily enroll in an alternative

benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
X	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):	Women who are not enrolled in an HMO	Southeastern Wisconsin
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
X	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	Pregnant women who are not enrolled in an HMO	Southeastern Wisconsin
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
X	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	Pregnant women who are not enrolled in an HMO	Southeastern Wisconsin
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In	Included Eligibility Group and Federal	Targeting	Geographic

Enrollment	Citation	Criteria	Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

Wisconsin has one of the worst infant mortality rates among African Americans in the country (rank 36 of 40). Key indicators of perinatal health include entry into prenatal care and rates for prematurity, low birth weight, and infant mortality. Prematurity and low birth weight are important risk factors for infant mortality and are themselves costly outcomes in terms of both the health of those infants and expensive medical care. Hospitalization costs alone in the first

year for a low birth weight baby can range from 10-50 times the cost for a normal birth weight baby. Approximately eighty-five percent of African American births in Wisconsin are to Medicaid mothers in the southeastern part of the state. The southeastern part of the state has the highest number of babies that die within the first year of life. Two counties (Milwaukee and Racine) in this part of the state have the highest and second highest rate (the number of infant deaths per 1000 live births) of infant mortality in the state.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, health care providers, Tribal governments, advocates, and the community about the program:

1. The state will hold a meeting with Tribal representatives to obtain their recommendations. Pregnant women who are identified as American Indian or Alaskan Native will be exempted if it is the recommendation from the Tribes.

2. The state will develop informing materials that:

   a. Identify the geographic area and the population to be enrolled in the program.
   b. Explain the nature of the voluntary enrollment, including the period of enrollment, exemption criteria, and the opt-out process
   c. Clearly inform women that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the enhanced services, including having an individualized care plan that is multi-disciplinary; addresses access and coordination across the full spectrum of a woman's needs.
   e. Provides a toll-free contact number for questions and information.

3. The state will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to individuals.
   b. Informing individuals about the voluntary nature of the program, including how to discontinue their participation.
   c. Informing individuals that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
   d. Educating pregnant women about the benefits of participating in this program, for example, improved communication and coordination between the medical prenatal care provider, specialty care providers and the pregnant woman.
   e. Documenting all requests for disenrollment

4. The state will make direct mailings to women informing them about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first two months.

5. The state will send written notification to the pregnant woman and inform her obstetric care provider and care coordinator of all disenrollments. The notification to the woman will explain that her regular benefit package will remain unchanged. The state will include the number for the Enrollment Specialist, should the woman have follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.
- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.
- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.
- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.
- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X☐ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

☐The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X☐ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan includes all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of pregnant women who are at a higher risk for a poor birth outcome. A key component is health care coordination, including: (a) the development of a comprehensive care plan that addresses physical, behavioral health and psychosocial needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation. The intention is to link the member to necessary services and resources in a coordinated effort to reduce her stress, ensure that all services are received and eliminate duplication of effort and services. The medical care will be patient-centered and evidence-based. Service delivery will include open and flexible scheduling and the use of non-traditional approaches to care.

1. Benefits will be provided under a medical home framework that includes the following:

   a. Assignment of an obstetric care provider who is experienced in providing care to high-risk pregnant women;
   b. Coordination of health care through a multidisciplinary team, including the obstetric care provider. The team identifies the health and psychosocial needs of each pregnant woman;

c. The identification of a team lead, which may be the obstetric care provider or a care coordinator;
d. Prompt development of a patient-centered, multidisciplinary care plan
e. Timely follow up on referrals
f. Establishment of regular communication between the obstetric care provider and other health care providers, including acute care (including emergency room visits), institutional care, chronic care and other specialty care;
g. Services provided through open and flexible scheduling;
h. Establishment of an electronic care plan and regular communication between, at a minimum, the obstetric care provider and the care coordinator.

2. This medical home framework, with its coordinated, comprehensive and patient-centered approach to services delivery will ensure that the unique needs of this population are addressed appropriately. The care coordinator will make home visits if appropriate, ensuring that the provision of medical prenatal care is linked to community resources and care. The care coordinator will ensure continuity of care between detention facilities and community health care should the woman be incarcerated during her pregnancy.

3. Providers will be required to offer the following services:

a. systematic assessment, counseling and referral for tobacco, alcohol and other substance abuse;
b. routine screening for domestic violence and depression;
c. evidence informed care and treatment, including screening for periodontal disease
d. an enhanced schedule for prenatal visits
e. mobile response and stabilization services;
f. oversight of psychotropic medication, including pharmacist consultant services;
g. increased schedule of laboratory tests related to the identification and treatment of infections that are known to prompt preterm labor in this population, including testing for urinary tract infections, STDs, asymptomatic bacteriuria, and Chlamydia

4. Up to 12 months of continued enrollment in the medical home to improve the health outcomes for low birth weight and pre-term infants. These infants are at an increased risk of dying in the first year of life. Continuation in the plan would be contingent on Medicaid eligibility and a judgment of necessity by the multidisciplinary care coordination team.

Note: For a summary of benefits under the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.
Please specify below which benchmark plan or plans this benefit package is equivalent to:
(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunizatio Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x☐ Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

This plan provides care coordination and enhanced access to pregnancy-related services for women in the southeastern counties. These women are at an increased risk of having a low birth weight or premature infant. These indicators are strong predictors of an infant dying in the first year of life. The plan includes all benefits under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of this population:

- A medical home framework specific to pregnant women. The following elements are critical components of this approach:
  - Early identification of the pregnancy
  - The assignment of a care coordinator
  - A comprehensive assessment of medical and psychosocial risk factors
  - The establishment of an electronic treatment plan that is accessible to all members of the woman's core team. The care plan must be patient-centered and address all aspects of the woman's medical and nonmedical care
  - A comprehensive, coordinated and integrated approach to care
  - The establishment of a multi-disciplinary team, with the obstetric care provider as an integral member of the care team. The care coordinator must be a core member of the team
  - Flexible and open scheduling
  - 24/7 support for the pregnant woman and her family
  - The use of evidence-based obstetric care guidelines in the delivery of services
  - The establishment of an automatic referral system between the medical home provider and hospitals, both inpatient and outpatient, to ensure that risk factors associated with the hospitalization or emergency room use are addressed within 24 hours of the event.
  - The establishment of procedures to systematically track patient test results and identify and follow up on abnormal test results
  - The establishment of a system to track referrals and ensure timely follow up on those referrals
  - The use of non-traditional approaches to addressing the unique needs of the population, this could include licensed midwives, in-home one-on-one peer support, and group prenatal visits
- Enhanced schedule of prenatal visits for women determined to be at higher risk for a preterm birth
- Increased lab testing as indicated, including urine dipstick at every visit
- Peer support and group prenatal visits offered

- Health literacy, including the appropriate use of the health care delivery system
- Enhanced patient education to include the following elements:
  - Patient self-management, including the signs of preterm labor and fetal movement
  - Stress reduction and medication management
  - Nutritional counseling
  - Abnormal weight gain
  - Child birth education, including counseling each trimester for women considering "trial of labor after cesarean" (TOLAC)
  - Breast feeding preparation and support
  - Early infant care, including safe sleep practices
- Home visits and/or links to community support programs, including WIC, food pantries, and faith-based organizations providing services and support to the community

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date)*.